Message to Benefit Recipients

The Benefit Choice Period will be held **May 1 through June 2, 2014**, for all benefit recipients not enrolled in, or eligible for, participation under the Medicare Advantage Program. **Benefit Choice elections will be effective July 1, 2014.**

Benefit recipients or dependent beneficiaries who have never been enrolled in CIP may enroll during the Benefit Choice Period. The Benefit Choice Period is the only time of year that a benefit recipient may change health plans, with the following two exceptions: the benefit recipient's permanent address changes affecting availability to their HMO plan or the primary care physician leaves the benefit recipient's HMO plan.

All Benefit Choice changes should be made on the CIP Benefit Choice form. Benefit recipients should complete the form only if changes are being made. If you are already enrolled in CIP and wish to make a change in coverage, please call the State Universities Retirement System (SURS) for a Benefit Choice form at (800) 275-7877 or visit the SURS website at **www.surs.org** or the Benefits website at **www.benefitschoice.il.gov**. The Benefit Choice form will only be sent upon request. If you are enrolling yourself or an eligible dependent for the first time during the Benefit Choice Period, please contact SURS for a CIP enrollment application. SURS will process the changes based upon the information indicated on the form.

During the Benefit Choice Period, benefit recipients may:

- Change health plans.
- Add dependent coverage if never previously enrolled (adding dependent coverage requires documentation).

Attention Annuitants and Survivors with Medicare Parts A and B: Members who, as of September 30, 2014, are enrolled in Medicare Parts A and B will be required to elect coverage under the CIP Medicare Advantage TRAIL Program or elect to opt out of all CIP coverage. Refer to page 2 for more information regarding the Medicare Advantage TRAIL Program.

Coverage and Monthly Premiums

Benefit recipients who enroll in the College Insurance Program (CIP) receive health, prescription, behavioral health, dental and vision coverage. Dependent beneficiaries can be enrolled in the program at an additional cost and will have the same health plan as the benefit recipient.

Type of Participant	Type of Plan	Not Medicare Primary	Not Medicare Primary	Not Medicare Primary	Medicare Primary*
		Under Age 26	Age 26-64	Age 65 and Above	All Ages
Benefit Recipient	Managed Care Plan	$103.79	$259.46	$362.23	$108.00
	College Choice Health Plan	$121.99	$304.96	$431.11	$105.99
Dependent Beneficiary	Managed Care Plan	$415.14	$1,037.86	$1,448.93	$431.99
	College Choice Health Plan	$487.94	$1,219.86	$1,724.44	$423.95

* This rate applies to plan participants enrolled in Medicare Parts A and B, or participants enrolled in Medicare Part A only and whose Part B benefits are reduced. Send a copy of your Medicare card to SURS. If you or your dependent is actively working and eligible for Medicare, or you have additional questions about this requirement, contact the CMS Group Insurance Division, Medicare Coordination of Benefits (COB) Unit.

What You Should Know for Plan Year 2015

It is each member's responsibility to know their plan benefits in order to make an informed decision regarding coverage elections. Members should carefully review all the information in this flyer to be aware of the benefit changes for the upcoming plan year. **The Benefit Choice Period will be May 1 through June 2, 2014**. All elections will be effective July 1, 2014.

- **Medicare Advantage 'TRAIL' Program:** Effective February 1, 2014, the State began a new Medicare Advantage Program, referred to as the 'TRAIL' (Total Retiree Advantage Illinois) for annuitants and survivors enrolled in both Medicare Parts A and B.

  Each fall, annuitants and survivors who meet the criteria for enrollment in the Medicare Advantage 'TRAIL' Program will be notified of the TRAIL Enrollment Period by the Department of Central Management Services. These members will be required to choose a Medicare Advantage plan or opt out of all CIP coverage (which includes health, behavioral health, prescription, dental and vision coverage) and will no longer be able to make changes during subsequent Benefit Choice Periods.

  For more information regarding the Medicare Advantage 'TRAIL' Program, including eligibility criteria, go to **www.cms.illinois.gov/thetrail**.

- **Federal Healthcare Reform:** As a result of the Patient Protection and Affordable Care Act, the out-of-pocket maximum amount for the open access plans (OAPs) have increased. Additionally, **Tier III no longer has an out-of-pocket maximum.** OAP Tiers I and II have combined charges contributing to the out-of-pocket maximum. Refer to page 13 of the Benefit Choice book for more information.
- **Express Scripts Mail Order:** Express Scripts is now the mail order pharmacy for the College Choice Health Plan (CCHP), HealthLink OAP plan and Coventry OAP plan.

Important Reminders

Power of Attorney: You must notify SURS if you have a financial or medical power of attorney (POA) who you would like to be able to make decisions and get information on your behalf if you are incapacitated.

- **Financial POA – used by your agent to change your health plan elections.** The financial POA document would allow an agent to make health and dental plan elections on your behalf and should be sent to your retirement system.
- **Medical POA – used by your agent to speak with your health, dental and vision plans about your coverage and claims.** A medical POA generally gives an agent the authority to make medical decisions on your behalf; therefore, in order for your agent to speak with your health, dental and/or vision plan(s), you would need to submit the medical POA document to each plan for them to have on file.

Terminating CIP Coverage: To terminate coverage at any time, notify SURS in writing. The cancellation of coverage will be effective the first of the month following receipt of the request. Benefit recipients and dependent beneficiaries who terminate from CIP may re-enroll only upon turning age 65, upon becoming eligible for Medicare or if coverage is involuntarily terminated by a former plan.

Documentation Requirements: Documentation, including the SSN, is required when adding dependent coverage.

Federally Required Notices

Notice of Creditable Coverage

Prescription Drug Information for CIP Medicare Eligible Plan Participants

This Notice confirms that the College Insurance Program has determined that the prescription drug coverage it provides is creditable. This means that your existing prescription coverage is on average as good as or better than the standard Medicare prescription drug coverage (Medicare Part D). You can keep your existing group prescription coverage and choose not to enroll in a Medicare Part D plan. Unless you qualify for low-income/extra-help assistance, you should not enroll in a Medicare Part D plan.

With this Notice of Creditable Coverage, you will not be penalized if you later decide to enroll in a Medicare prescription drug plan. However, you must remember that if you drop your entire group coverage through CIP and experience a continuous period of 63 days or longer without creditable coverage, you may be penalized if you enroll in a Medicare Part D plan later. If you choose to drop your CIP coverage, the Medicare Special Enrollment Period for enrollment into a Medicare Part D plan is two months after the loss of creditable coverage.

If you keep your existing group coverage, it is not necessary to join a Medicare prescription drug plan this year. Plan participants who decide to enroll into a Medicare prescription drug plan; however, may need a personalized Notice of Creditable Coverage in order to enroll into a prescription plan without a financial penalty. Participants who need a personalized Notice may contact the State of Illinois Medicare Coordination of Benefits Unit at (800) 442-1300 or (217) 782-7007.

Summary of Benefits and Coverage (SBC) and Uniform Glossary

Under the Affordable Care Act, health insurance issuers and group health plans are required to provide you with an easy-to-understand summary about a health plan's benefits and coverage. The regulation is designed to help you better understand and evaluate your health insurance choices.

The forms include a short, plain language Summary of Benefits and Coverage (SBC) and a uniform glossary of terms commonly used in health insurance coverage, such as "deductible" and "copayment."

All insurance companies and group health plans must use the same standard SBC form to help you compare health plans. The SBC form also includes details, called "coverage examples," which are comparison tools that allow you to see what the plan would generally cover in two common medical situations. You have the right to receive the SBC when shopping for, or enrolling in, coverage or if you request a copy from your issuer or group health plan. You may also request a copy of the glossary of terms from your health insurance company or group health plan. All CIP health plan SBC's are available on the Benefits website.

Notice of Privacy Practices

The Notice of Privacy Practices has been updated on the Benefits website effective April 1, 2013. You have a right to obtain a paper copy of this Notice, even if you originally obtained the Notice electronically. We are required to abide with terms of the Notice currently in effect; however, we may change this Notice. If we materially change this Notice, we will post the revised Notice on our website at **www.benefitschoice.il.gov**.

Map of Health Plans by Illinois County

July 1, 2014 through June 30, 2015

Refer to the code key below for the health plan code for each plan by county.

BlueAdvantage HMO . . . CI
Coventry HMO . . . . . AS
Coventry OAP. . . . . CH
Health Alliance HMO . . . AH
HealthLink OAP . . . . . CF
HMO Illinois . . . . . BY
College Choice Health Plan (CCHP) D3

AH, AS, BY, CF, CH, CI, D3

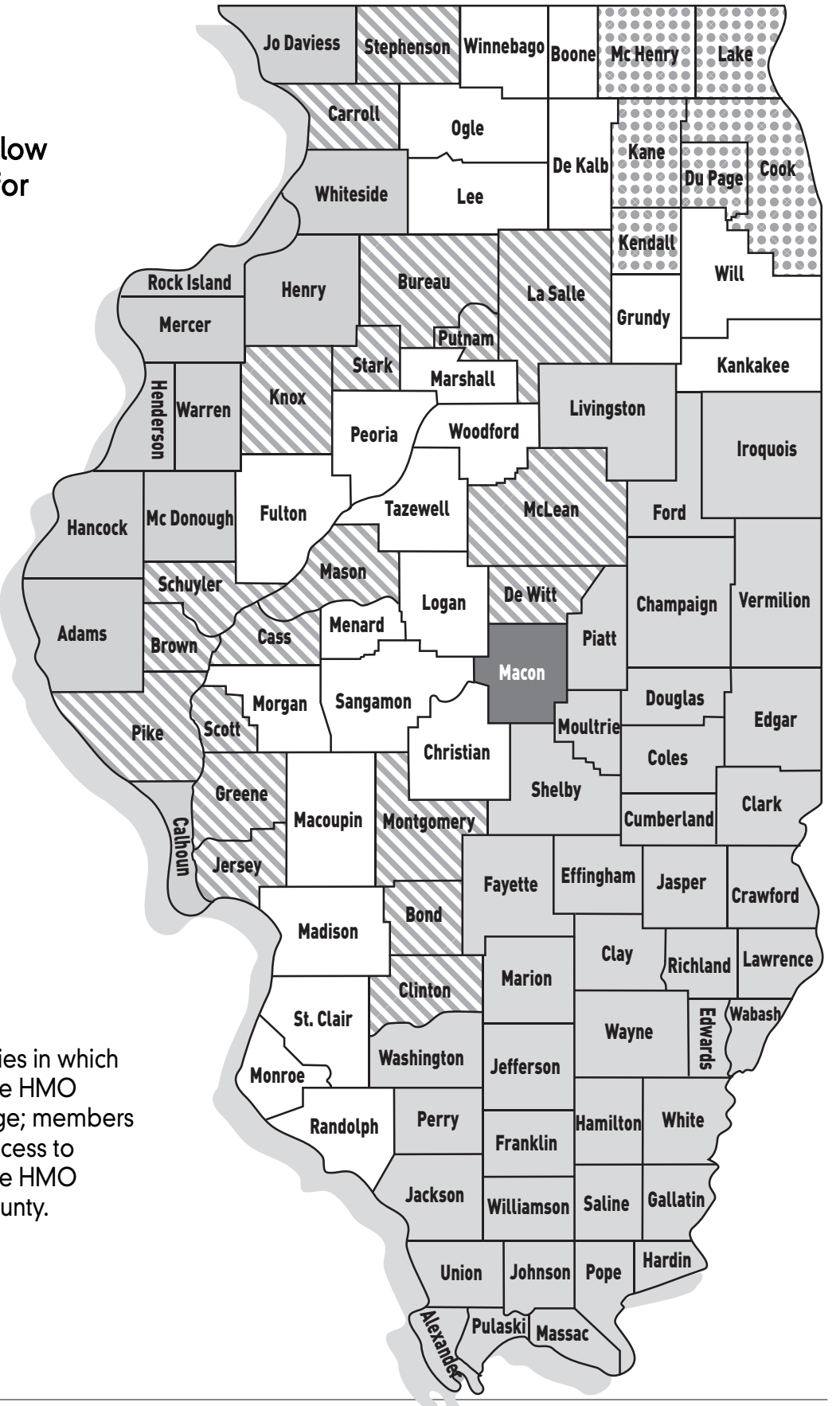
BY, CF, CH, CI, D3

AH, AS, CF, CH, D3

AH, AS, CF, CH, CI, D3

AH, AS, BY, CF, CH, CI, D3

Striped areas represent counties in which HMO Illinois or BlueAdvantage HMO do not have provider coverage; members in these counties may have access to HMO Illinois or BlueAdvantage HMO providers in a neighboring county.



HMO Benefits

Plan participants must select a primary care physician (PCP) from a network of participating providers. The PCP directs healthcare services and must make referrals for specialists and hospitalizations. When care and services are coordinated through the PCP, the plan participant pays only a copayment. No annual plan deductibles apply. The HMO coverage described below represents the minimum level of coverage an HMO is required to provide. Benefits are outlined in each plan's summary plan document (SPD). It is the plan participant's responsibility to know and follow the specific requirements of the HMO plan selected. Contact the plan for a copy of the SPD.

HMO Plan Design	
Plan year maximum benefit	Unlimited
Lifetime maximum benefit	Unlimited
Hospital Services	
Inpatient hospitalization	100% after $250 copayment per admission
Alcohol and substance abuse	100% after $250 copayment per admission
Psychiatric admission	100% after $250 copayment per admission
Outpatient surgery	100% after $200 copayment
Diagnostic lab and x-ray	100%
Emergency room hospital services	100% after $200 copayment per visit
Professional and Other Services (Copayment not required for preventive services)	
Physician Office visit	100% after $30 copayment per visit
Preventive Services, including immunizations	100%
Specialist Office visit	100% after $30 copayment per visit
Well Baby Care (first year of life)	100%
Outpatient Psychiatric and Substance Abuse	100% after $30 copayment per visit
Prescription drugs (30-day supply) (formulary is subject to change during plan year)	$12 copayment for generic $24 copayment for preferred brand $48 copayment for nonpreferred brand $96 copayment for specialty
Durable Medical Equipment	80%
Home Health Care	100% after $30 copayment per visit

Some HMOs may have benefit limitations based on a calendar year.

Open Access Plan (OAP) Benefits

The benefits described below represent the minimum level of coverage available in an OAP. Benefits are outlined in the plan's summary plan document (SPD). It is the member's responsibility to know and follow the specific requirements of the OAP plan. Contact the plan for a copy of the SPD.

Benefit	Tier I 100% Benefit	Tier II 80% Benefit	Tier III (Out-of-Network) 60% Benefit
Plan Year Maximum Benefit	Unlimited	Unlimited	Unlimited
Lifetime Maximum Benefit	Unlimited	Unlimited	Unlimited
Annual Out-of-Pocket Max Per Individual Enrollee Per Family	$6,250 (includes eligible charges from Tier I and Tier II combined) $12,700 (includes eligible charges from Tier I and Tier II combined)		Not Applicable
Annual Plan Deductible (must be satisfied for all services)	$0	$300 per enrollee*	$400 per enrollee*
Hospital Services			
Inpatient	100% after $250 copayment per admission	80% of network charges after $300 copayment per admission	60% of allowable charges after $400 copayment per admission
Inpatient Psychiatric	100% after $250 copayment per admission	80% of network charges after $300 copayment per admission	60% of allowable charges after $400 copayment per admission
Inpatient Alcohol and Substance Abuse	100% after $250 copayment per admission	80% of network charges after $300 copayment per admission	60% of allowable charges after $400 copayment per admission
Emergency Room	100% after $200 copayment per visit	100% after $200 copayment per visit	100% after $200 copayment per visit
Outpatient Surgery	100% after $200 copayment per visit	80% of network charges after $200 copayment	60% of allowable charges after $200 copayment
Diagnostic Lab and X-ray	100%	80% of network charges	60% of allowable charges
Physician and Other Professional Services **(Copayment not required for preventive services)**			
Physician Office Visits	100% after $30 copayment	80% of network charges	60% of allowable charges
Specialist Office Visits	100% after $30 copayment	80% of network charges	60% of allowable charges
Preventive Services, including immunizations	100%	100%	Covered under Tier I and Tier II only
Well Baby Care (first year of life)	100%	100%	Covered under Tier I and Tier II only
Outpatient Psychiatric and Substance Abuse	100% after $30 copayment	80% of network charges	60% of allowable charges
Other Services			
Prescription Drugs (30-day supply) – Covered through the plan administrator, Express Scripts Generic $12 Preferred Brand $24 Nonpreferred Brand $48 Specialty $96			
Durable Medical Equipment	80% of network charges	80% of network charges	60% of allowable charges
Skilled Nursing Facility	100%	80% of network charges	Covered under Tier I and Tier II only
Transplant Coverage	100%	80% of network charges	Covered under Tier I and Tier II only
Home Health Care	100% after $30 copayment	80% of network charges	Covered under Tier I and Tier II only

* An annual plan deductible must be met before Tier II and Tier III plan benefits apply. Benefit limits are measured on a plan year. Amounts over the plan's allowable charges do not count toward the out-of-pocket maximum.

The College Choice Health Plan (CCHP)

Plan Year Maximums and Deductibles	
Plan Year Maximum	Unlimited
Lifetime Maximum	Unlimited
Plan Year Deductible	$750 per participant
Additional Deductibles* * These are in addition to the plan year deductible.	Each emergency room visit $400 CCHP hospital admission $250 Non-CCHP hospital admission $500 Transplant deductible $250

Out-of-Pocket Maximum Limits			
In-Network Individual	In-Network Family	Out-of-Network Individual	Out-of-Network Family
$1,500	$3,000	$4,500	$9,000

Hospital Services	
CCHP Hospital Network	$250 deductible per hospital admission. 80% after annual plan deductible.
Non-CCHP Hospitals	$500 deductible per hospital admission. 60% of allowable charges after annual plan deductible.

Outpatient Services	
Preventive Services, including immunizations	100% in-network, 60% of allowable charges out-of-network, after annual plan deductible.
Diagnostic Lab/X-ray	80% in-network, 60% of allowable charges out-of-network, after annual plan deductible.
Approved Durable Medical Equipment (DME) and Prosthetics	
Licensed Ambulatory Surgical Treatment Centers	

Professional and Other Services	
Services included in the CCHP Network	80% after the annual plan deductible.
Services not included in the CCHP Network	60% of allowable charges after the annual plan deductible.
Chiropractic Services – medical necessity required (up to a maximum of 30 visits per plan year)	80% in-network, 60% of allowable charges after the annual plan deductible.

Transplant Services	
Organ and Tissue Transplants	80% after $250 transplant deductible, limited to network transplant facilities as determined by the medical plan administrator. Benefits are not available unless approved by the Notification Administrator, Cigna. To assure coverage, the transplant candidate must contact Cigna prior to beginning evaluation services.

Prescription Drugs (administered by Express Scripts)	
Prescription Drugs (30-day supply)	Generic $12.50 Preferred Brand $25.00 Nonpreferred Brand $50.00 Specialty $100.00

Benefit Choice is May 1 - June 2, 2014

Benefit Choice Forms must be submitted to SURS no later than Monday, June 2nd!

If you do not want to change your coverage, you do not need to submit a form.

It is each member's responsibility to know plan benefits and make an informed decision regarding coverage elections. The complete Benefit Choice Options booklet and Benefit Choice form can be found on the Benefits website at **www.benefitschoice.il.gov**

Go to the 'Latest News' section of the Benefits website at
www.benefitschoice.il.gov
for group insurance updates throughout the plan year.